STATE OF MARYLAND

MARYLAND HEALTH CARE COMMISSION

4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
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MEMORANDUM

TO: Commissioners, Maryland Health Care Commission
Capital Hospice, Inc. (d/b/a Capital Caring)
Hospice of the Chesapeake

FROM: Commissioner Glenn Schneider, Reviewer

RE: Recommended Decision in the Matter of Capital Hospice, Inc., d/b/a Capital Caring, Docket No. 13-16-2343
Proposed General Inpatient Hospice Unit

DATE: May 13, 2014

Enclosed is my Recommended Decision in the review of the above-referenced project. Capital Caring proposes to establish a seven-bed general inpatient (GIP) hospice unit in leased space on the third floor of an assisted living facility in Lanham, in Prince George's County. Having considered the initial applications, comments on the applications, including those of an interested party (Hospice of the Chesapeake) and the entire record in this review, I recommend that the application of Capital Caring to create this inpatient facility be approved.

This matter will be placed on the agenda for a meeting of the Maryland Health Care Commission on June 19, 2014 at the Commission offices, 4160 Patterson Avenue, in Baltimore. The meeting will begin at 1:00 pm. The Commission will issue a final decision based on the record of the proceeding.

As provided under COMAR 10.24.01.09B, the applicant and the interested party may submit written exceptions to the enclosed Recommended Decision and Order. **Exceptions should be filed no later than May 27, 2014.** Written exceptions and argument must identify specifically those findings or conclusions to which exception is taken, citing the portions of the record on which each exception is based. The applicant and the interested party must submit 40 copies of their written exceptions and responses to exceptions. **Responses to exceptions should be filed no later than June 9, 2014.**

Oral argument during the exceptions hearing before the Commission will be limited to 15 minutes for the applicant and 10 minutes for the interested party, unless extended by the Chair or the Chair's designated presiding officer. The schedule for the submission of exceptions and responses is as follows:

Submission of exceptions	May 27, 2014 No later than 4:00 pm
Submission of responses	June 9, 2014 No later than 4:00 pm
Exceptions hearing	June 19, 2014 Meeting will begin at 1 pm

IN THE MATTER OF	*	**BEFORE THE**
	*	
CAPITAL HOSPICE, INC. d/b/a CAPITAL CARING	*	**MARYLAND HEALTH**
	*	
	*	**CARE COMMISSION**
Docket No. 13-16-2343	*	
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Reviewer's Recommended Decision

May 13, 2014

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I. INTRODUCTION

A. Overview

The proposed project that is the subject of this Certificate of Need (CON) application before the Maryland Health Care Commission (MHCC) would create a 7-bed general inpatient hospice unit (GIP) on the third floor of an assisted living facility in Lanham, in Prince George's County. There is currently no GIP operated by a hospice program in this populous county, despite the fact that nine hospice[1] organizations are authorized to provide services there. Under the need methodology in the recent replacement chapter of the State Health Plan for Facilities and Services (State Health Plan) that addresses hospice services, COMAR 10.24.13 (Hospice Chapter) Prince George's County is currently identified as a jurisdiction in which the establishment of an additional hospice provider should be considered, a fact related to the relatively low use of hospice services by the jurisdiction's population, currently one of the lowest use rates in the State.

The applicant is Capital Hospice, Inc. d/b/a Capital Caring ("Capital Caring"), headquartered in Falls Church, Virginia. Prince George's County is the only Maryland county that Capital Caring is authorized to serve.

Challenging this application is Hospice of the Chesapeake (HOC), a general hospice serving Anne Arundel and Prince George's Counties that was recognized as an interested party in this review. The basis of HOC's opposition to this project is that the 14-bed GIP for which it received CON approval in September of 2012 was projected to obtain some hospice patients residing in northern Prince George's County as a portion of its census. The interested party states that it would be negatively affected by Capital Caring's proposed project.

B. The Project

The applicant proposes to lease space on the third floor of the Residence on Greenbelt, an assisted living facility in Lanham. The applicant would create a 7-bed inpatient hospice facility. Three of the private rooms will have private bathrooms and the other four private rooms will share bathrooms (two patient rooms per one shared bathrooms).

The hospice unit will have a dedicated entrance and elevator. There will also be a medical supply room, linen room, equipment storage, staff meeting/break room, and work stations for the social worker, chaplain and part time physicians. The total estimated cost is projected to be $458,343, broken down as follows:

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[1] Even though nine hospices are authorized to provide general hospice services in Prince George's County, four of those hospices serve 90% of the patients who use general hospice services in the county.

• Building renovations	$283,826
• Fixed equipment (nurse call system, telecom, and IT)	24,934
• Architect/engineering fees	67,900
• Permits	8,300
• Major movable equipment	28,383
• Minor movable equipment	5,000
• Contingency	20,000
• CON-related legal fees	20,000
	$458,343

Capital Caring will fund the project with cash reserves.

C. The Applicant

Capital Caring is a not-for-profit agency founded in 1977 that is headquartered in Virginia. It provides hospice and palliative care services for patients and families from neighborhood offices in Virginia (Arlington, Alexandria, Falls Church, Fredericksburg, Leesburg, Manassas), Maryland (Largo), and Washington, DC.

Capital Caring is authorized to provide general hospice services in Prince George's County, currently providing home-based care from its office in Largo. Capital Caring operates a 15-bed inpatient hospice facility in Arlington, Virginia (Halquist Memorial Inpatient Center).

In Maryland, Capital Caring provides general inpatient care by contracting with three hospitals – Prince George's Hospital Center in Cheverly, Laurel Regional Hospital in Laurel, and MedStar Southern Maryland Hospital Center in Clinton. Such arrangements are permitted under applicable federal and State law, because every licensed and Medicare-certified general hospice is obligated to make provisions for inpatient care. General hospices can establish such agreements with hospitals without CON approval when the agreements conform with policies of the Health Services Cost Review Commission (HSCRC). Under its General Inpatient Hospice Care Project, the HSCRC permits hospitals to enter into HSCRC-approved arrangements with hospices to accept less than HSCRC-approved rates and to write off as a voluntary contractual allowance the difference between approved charges and the reimbursement by the hospice. CON approval is not required because, under such arrangements, the bed capacity of a health care facility does not change. The hospital beds are only episodically used to accommodate hospice patients.

D. Background

In FY12, Capital Caring attended to 745 of the 2,017 total patients receiving hospice services in Prince George's County, making it the single largest provider of such care in the county (a 37% market share). Hospice of the Chesapeake was the second largest hospice service provider with 546 patients (27%). Other hospice organizations with at least a 10% share of the Prince George's market included Heartland Hospice – Beltsville (15%) and Community Hospice of Maryland (11%).

E. Summary of Recommended Decision

Based on my review of the record, including the submissions from the interested party, I recommend that the Maryland Health Care Commission approve this project.

My recommendation is based on my findings with respect to the compliance of the proposed project with the applicable standards of the Hospice Chapter of the State Health Plan, the need for this project, the costs and effectiveness of alternatives to this project, the viability of this project, and the impact of this project. My findings on these review criteria are outlined in this Recommended Decision.

II. PROCEDURAL HISTORY

A. Record of the Review

See Appendix 1.

B. Local Government Review and Comment

Rushern Baker, III, Prince Georges County Executive, wrote a general letter of support for the project.

C. Interested Parties in the Review

I recognized Hospice of the Chesapeake (HOC), a general hospice serving Anne Arundel and Prince George's Counties, as an interested party in this review, opposing the project.

HOC began in 1979 as "Arundel Hospice," and became "Hospice of the Chesapeake" on December 31, 1991. It provides hospice care in various settings, including private homes, nursing homes, assisted living facilities, hospitals, and its own residential and inpatient facilities. HOC provides residential care at its 8-bed Creston G. & Betty Jane Tate Foundation Chesapeake Hospice House in Linthicum and general inpatient hospice care at its 8-bed Mandrin Inpatient Care Center in Harwood, both located in Anne Arundel County. On September 20, 2012, HOC was granted a CON to construct a 14-bed general inpatient unit in Pasadena (Anne Arundel County).

According to MHCC Hospice Surveys, HOC provided hospice care to 85% of those Anne Arundel County patients receiving hospice care in both 2011 and 2012. In Prince George's County, the other jurisdiction in which it is authorized, HOC served 25% of those receiving hospice care in 2011 and 27% in 2012. In the same years, Capital Caring served 32% and 37% respectively. Prince George's County patients accounted for 16.7% of the total hospice care provided by HOC.

D. Other Support and Opposition to the Project

Letters of support for the Capital Caring project were received from:

- Elizabeth Morton, RN, of Laurel Regional Hospital (Advance Care Planning/Quality Improvement) whose letter speaks to the applicant's: experience with GIP service in

its Arlington inpatient facility; 35-year presence in Prince George's County; and strong ties with most local hospitals. Ms. Morton also states that the population is underserved in this – and other – health care services.

- Anne White of Gethsemane United Methodist Church (Community Outreach) discussed "the lack of health care and health care providers" in the county and expressed confidence in Capital Caring's ability to fill a need because of its long standing experience.
- Neal Kursban, President of Family & Nursing Care (a nursing referral service agency and residential service agency in Silver Spring, Maryland) wrote about the importance of having a home-like inpatient hospice provider to encourage placement of patients at the right level of care, and also addressed Capital Caring's history of providing care to patients without regard to their ability to pay for services.
- Cherrie Dupree, R.N., of Clinton Nursing and Rehabilitation Center (a nursing home), whose letter expresses the local need for convenient access to hospice services including general inpatient care.

III. THE ENVIRONMENT

A. Demographics: Key Facts and Trends

- Prince George's County is the second most populous county in Maryland (863,420 persons in 2010) and its population is projected to grow to almost 892,000 by 2015, an increase of approximately 3.3% over a five-year period (slightly lower growth rate than the State as a whole).
- Although the percentage of the population aged 65+ is lower than that for the State overall, the county has a large and rapidly growing senior population, with 81,510 persons aged 65+ in 2010, and a projected increase to more than 102,000 elderly in 2015, a 25% increase over five years, a rate of increase well above the statewide rate.

Jurisdiction	2010 Total Population	% Change, Total Population 2010 - 2015	2010 65+ Population	% Change, 65+ Population 2010 - 2015	% of Total Population Aged 65+, 2015
Maryland	5,773,552	3.6%	707,642	18%	14%
Prince George's County	863,420	3.3%	81,513	25%	11%

Source: Maryland Department of Planning.

- Of the total Prince George's County population, 65% is Black/African American and 15% is Hispanic/Latino (15.3%). These two groups account for only 38.7% of the State's population, compared to Prince George's 81%.
- Prince George's economic indicators, from the 2010 census, show a mixed picture. While median household income is slightly above the statewide level, per capita income and the rate of home ownership in Prince George's County lag the State

average, even as the proportion of the population in poverty is lower than the statewide level.

Economic Indicator	Prince George's County	Maryland
Median household income	$73,560	$72,999
Persons below poverty level	8.7%	9.4%
Per capita money income	$32,254	$36,056
Homeownership rate	63.4%	68.1%

Source: US Census QuickFacts – Prince George's County

Since 2009, federal Bureau of Labor Statistics (BLS) estimates of unemployment for Maryland and its counties show that employment levels in Prince George's County have been equal to or slightly better than that for the State overall. The estimated unemployment rate for Prince George's County for January 2014 was reported by the Maryland Department of Labor, Licensing and Regulation BLS as 6.2%, while it was 6.1% for all of Maryland. In the four years prior to 2009, the jurisdiction registered slightly higher levels of unemployment than the State average.

B. Hospice Utilization and Providers in Prince George's County

Overall hospice use rates (routine home care, inpatient care, respite care, and continuous care) in Prince George's County are among the lowest in the State – 22% of deaths, compared to a State Health Plan "target rate" of 45%.

Five Counties with the Highest Hospice Use	Use Rate 2011	Five Counties with the Lowest Hospice Use	Use Rate 2011
Baltimore Co.	.54	Caroline	.18
Cecil	.54	Dorchester	.19
Carroll	.53	Allegany	.22
Anne Arundel	.47	Prince George's	.22
St. Mary's	.47	Baltimore City	.25

Source: COMAR 10.24.13: Supplement Tables – State Health Plan for Facilities and Services: Hospice Services Chapter Statistical Tables

Nine hospices are authorized to provide services in Prince George's County. As can be seen in the following table, historically, four hospice providers have accounted for at least 90% of the service provided – Capital Caring, Hospice of the Chesapeake, Heartland Hospice-Beltsville, and Community Hospice of Maryland. Over the 2008-2012 period, Capital Caring has seen its market share grow by ten percentage points, while all others have remained static or yielded share.

Hospice	2008	2009	2010	2011	2012	% share 2008	% share 2012
Capital Caring	444	416	502	581	745	26.9%	36.9%
Hospice of the Chesapeake Inc	441	442	458	449	546	26.8%	27.1%
Heartland Hospice - Beltsville	491	320	385	383	309	29.8%	15.3%
Community Hospice of MD	176	186	136	159	219	10.7%	10.9%
Evercare Hospice and Palliative Care	39	52	78	82	68	2.4%	3.4%
Seasons Hospice of Maryland	15	84	145	132	60	0.9%	3.0%
Holy Cross Home Care & Hospice	32	31	35	31	51	1.9%	2.5%
Joseph Richey Hospice	--	--	--	--	9	--	0.4%
Gilchrist Hospice Care	4	4	6	3	9	0.2%	0.4%
*Stella Maris Inc.**	6	1	9	1	--	0.4%	--
Jewish Social Service Agency Hospice *	--	--	1	1	1	--	0.0%
TOTALS	1,648	1,536	1,755	1,822	2,017	xxxxxxx	xxxxxxx

Source: MHCC Hospice Surveys

* *These hospices not authorized to provide general hospice services in Prince Georges County. They may have provided services: under a specific exception issued by MHCC that permitted hospice provision to a specific patient; or to a Prince George's County resident in the hospice's inpatient facility in another jurisdiction.*

Among the hospices dominant in Prince George's County, only Capital Caring, with its Arlington, Virginia facility, and HOC with its Harwood and Pasadena sites, provide general inpatient services in freestanding facilities that they operate as part of their licensed general hospice programs.

IV. PROJECT CONSISTENCY WITH REVIEW CRITERIA

A. COMAR 10.24.01.08G(3)(a) THE STATE HEALTH PLAN and COMAR 10.24.08.14 HOSPICE STANDARDS

COMAR 10.24.01.08G(3)(a) The State Health Plan. An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards, policies, and criteria.

This application was filed and docketed prior to the effective date (October 14, 2013) of the current State Health Plan chapter governing hospice services, COMAR 10.24.13. For this review, **COMAR 10.24.08, the State Health Plan for Facilities and Services: Nursing Home, Home Health Agency, and Hospice Services,** which was effective as of March 12, 2007, is applicable. COMAR 10.24.08.14-16 (hospice regulations) apply to this review, and the specific standards at **COMAR 10.24.08.14, Hospice Standards**, are used to review Certificate of Need applications to establish new general hospice programs, or expand an existing hospice program to one or more additional jurisdictions; however, the standards are silent on the subject of inpatient hospice bed need, and thus of limited help in considering this project, which involves changes in the bed capacity of an existing general hospice. Only nine of the State's 27 general hospices operate their own inpatient facilities under their hospice license.

.14A. Service Area.

.14A. Service Area. An applicant shall designate the jurisdiction in which it proposes to provide services.

Capital Caring is authorized to provide general hospice services in Prince George's County. It currently provides home-based care from its office in Largo, and proposes to add a general inpatient hospice unit in the Residence on Greenbelt.

The applicant cites the Maryland Department of Planning's May 2012 report to point out that Prince George's County is the second most populous in Maryland (863,420 in 2010) and is projected to grow to 882,200 in 2015, an increase of approximately 2.2% over a 5-year period. (DI#2)

The applicant also notes that the county has a large and rapidly growing senior population, with 81,510 persons aged 65+ in 2010, projected to increase to 103,950 in 2015, a 27.5% increase over the five-year period. The applicant draws the conclusion that the size and growth of the elderly population suggest the need for a full complement of services for advanced illness care that is readily accessible to the community. (DI#2)

I find that the applicant has complied with this standard.

.14B. Admission Criteria.

.14B. Admission Criteria. An applicant shall identify:

(1) Its admission criteria; and

(2) Proposed limits by age, disease or caregiver.

Capital Caring follows the Center for Medicare and Medicaid Services (CMS) criteria for admission to hospice care. Under these criteria, potential patients must be certified by at least two physicians to have a terminal illness with a prognosis of six months or less to live if the illness follows its normal course. Patients who meet this condition must elect hospice care rather than other Medicare-covered benefits for treatment of illness.

The applicant's guidelines for admission to GIP level of care include: pain requiring technical delivery of medication with skilled nursing care; frequent evaluation by a physician or nurse; aggressive treatment to control pain; frequent medication adjustment; symptom changes requiring intensive nursing intervention; uncontrolled nausea; pathological fractures; respiratory distress; wound care requiring complex or frequent dressing changes; and imminent death requiring symptom management with skilled nursing intervention.

There are no limits to admission at the proposed GIP based on patient age or caregiver. Patients who have a disease involving airborne infection (e.g., tuberculosis) will not be admitted, however, as the facility will not have an isolation room that provides negative pressure. All seven rooms will be private; the applicant states that this room configuration, coupled with

strong infection control policies, will provide effective protection for other infectious risks. (DI#2)

I find that the applicant has complied with this standard.

.14C. Minimum Services.

(1) An applicant shall provide the following services directly:

(a) Physician services and medical direction;

Capital Caring reports that it employs 22 physicians, who are fellowship-trained in palliative medicine. This internal physician group will staff and direct the proposed unit. (DI#2)

(b) Skilled nursing care;

The applicant states that the unit staffing will include an RN in charge on a 24/7 schedule, as well as a certified nursing assistant. (DI#2)

(c) Counseling or social work;

Capital Caring notes that a social worker based in its Largo office will staff the unit and provide all patient and family psycho-social support as well as discharge planning assistance. (DI#2)

(d) Spiritual services;

In response to this standard, Capital Caring states that a chaplain based in its Largo office will staff the unit and attend to the spiritual needs of patients and families.

(e) Nutritional counseling; and

Capital Caring reports that its registered dietitian employee will be available for consultation and will partner with the food service staff at Residence on Greenbelt to ensure compliance with diet orders. (DI#2)

(f) On-call nursing response

The applicant assures that the unit will be staffed on a 24 hours/7 day per week basis. (DI#2)

I find that the applicant has complied with this standard.

(2) An applicant shall also provide the following services, either directly or through contractual arrangements:

(a) Personal care;

Capital Caring states that a certified nursing assistant (CNA) will be present on the unit at all times. This care will be supplemented by patient care volunteers. (DI#2)

(b) Volunteer services;

As noted above, Capital Caring plans to use volunteers to supplement the personal care given by CNAs. It will recruit volunteers for the following additional functions: to provide hospitality such as afternoon tea; to provide integrative therapies such as pet therapy, art and music therapies, and massage/Reiki; and to perform administrative services. (DI#2)

(c) Bereavement services;

Capital Caring will provide bereavement services to all patients and families, to be coordinated by the Capital Caring regional office that is closest to the residence of those requesting bereavement support. In most cases, this will be the Largo office. (DI#2)

(d) Pharmacy services;

The applicant states that it will contract with a pharmacy in the community to provide medications needed for direct patient care in the facility. Wise Hospice Options, a pharmacy benefits manager, will oversee the required regulatory inspections of the medication room and associated processes. (DI#2)

(e) Laboratory, radiology, and chemotherapy services as needed for palliative care;

The applicant will contract for laboratory and radiology services with a hospital or health care facility in the community. The applicant does not anticipate providing chemotherapy in the facility. (DI#2)

(f) Medical supplies and equipment; and

Capital Caring responded to this standard by stating that its purchasing agent will purchase medical supply and equipment. (DI#2)

(g) Special therapies, such as physical therapy, occupational therapy, speech therapy, and dietary services.

Capital Caring maintains a contractual relationship for respiratory and physical therapy. Therapists will be available as needed for patient care in the facility. (DI#2)

I find that the applicant has complied with this standard.

(3) An applicant shall provide bereavement services to the family for a period of at least one year following the death of the patient.

Capital Caring states that it will provide bereavement services to the family for thirteen months following the death of the patient. This service will be coordinated by the Capital Hospice office that is located closest to the family's home in order to offer the most convenient service. (DI#2)

I find that the applicant has complied with this standard.

.14D. Setting.

.14D. Setting. An applicant shall specify where hospice services will be delivered: in a private home; a residential unit; an inpatient unit; or a combination of settings.

Capital Caring's proposed 7-bed inpatient unit will be located on the third floor of the Residence on Greenbelt, 9885 Greenbelt Road, Lanham, Maryland, but will have a separate entrance. The Residence on Greenbelt is an independent and assisted living facility owned and operated by IntegraCare of Wexford, Pennsylvania. The 95-bed facility provides a range of services including four distinct lifestyle options – Independent Living, Assisted Living, Special Needs, and Pathways Memory Care. Capital Caring will lease a portion of the third floor from IntegraCare, and will fund the renovations needed to support hospice inpatient care in the facility. (DI#2)

I find that the applicant has complied with this standard.

.14E. Volunteers.

.14E. Volunteers. An applicant shall have available sufficient trained caregiving volunteers to meet the needs of patients and families in the hospice program.

Capital Caring states that it has sufficient capacity to recruit and train volunteers for the proposed inpatient facility. Its existing inpatient unit, a 15-bed facility in Arlington Virginia, includes 150 trained volunteers who support its patients and staff. The Largo regional office presently has 30 volunteers providing support to patients in the Prince George's service area. Additional volunteers will be recruited to support the proposed inpatient unit. (DI#2)

New volunteers will be required to complete an application and interview process that includes a background check. Following confirmation of eligibility, volunteers will participate in a general orientation program that includes education on hospice care and Capital Caring's policies and procedures. The initial orientation is usually completed in eight hours. Additionally, patient care volunteers receive an orientation to care at the bedside and shadow an experienced volunteer for eight hours prior to beginning their regular schedules. (DI#2)

I find that the applicant has complied with this standard.

.14F. Caregivers.

.14F. Caregivers. An applicant shall provide, in a patient's residence, appropriate instruction to, and support for, persons who are primary caretakers for a hospice patient.

The proposed inpatient facility will provide space for family members to stay overnight in the patient's room, as well as space for family meetings and a meditation room. Meals will be available on the unit for families as needed. The nursing staff provides teaching at the bedside for families who anticipate taking the patient home for care following the inpatient stay. (DI#2)

I find that the applicant has complied with this standard.

.14G. Financial Accessibility.

.14G. Financial Accessibility. An applicant shall be licensed and Medicare-certified, and agree to accept clients whose expected primary source of payment is Medicare or Medicaid.

Capital Caring is licensed in Maryland, the District of Columbia, and Virginia, accepts Medicaid, and is Medicare-certified. Capital Caring accepts patients regardless of their ability to pay for care. In 2012, the organization provided over $2.3 million dollars in charity care, or 3.4% of net patient services revenue. (DI#2)

I find that the applicant has complied with this standard.

.14H. Information to Providers and the General Public.

(1) General Information. An applicant shall inform the following entities about the program's services, service area, reimbursement policy, office location, and telephone number:

(a) All hospitals, nursing homes, and assisted living providers within its proposed service area;

(b) At least five physicians who practice in its proposed service area;

(c) The Senior Information and Assistance Offices located in its proposed service area; and

(d) The general public in its proposed service area.

Capital Caring states that it is a well-established hospice care provider in Prince George's County, and that it has provided information about its services to hospitals, nursing homes, assisted living facilities, physician offices, the county's Senior Information and Assistance Program office, and the general public. If and when approved, detailed information on the new inpatient facility will be provided to all of these entities and to the general public. (DI#2)

I find that the applicant has complied with this standard.

(2) Fees. An applicant shall make its fees known to clients and their families before services are begun.

Capital Caring states that it makes its fee schedule available to all patients and families who are referred for care. The organization participates in most major health plans, including Medicare and Medicaid. Capital Caring also maintains a patient care fund to support the care of patients who have limited financial resources. (DI#2)

I find that the applicant has complied with this standard.

.14I. Time Payment Plan.

.14I. Time Payment Plan. An applicant shall:

(1) Establish special time payment plans for individuals unable to make full payment at the time services are rendered; and

Capital Caring states that a time payment plan is available when necessary to support patients and families. An excerpt from its Hospice Payment Options policy provides that "[t]ime payment plans will be made available when appropriate; Capital Hospice will provide fee reduction to patients, qualified as financially needy." (DI#2)

I find that the applicant has complied with this standard.

(2) Submit to the Commission and to each client a written copy of its policy detailing time payment options and mechanisms for clients to arrange for time payment.

Capital Caring has provided the Commission with a copy of its policy AD.H55, Hospice Payment Options. The policy details time payment options and how patients/families can arrange for it. (DI#2)

I find that the applicant has complied with this standard.

.14J. Charity Care and Sliding Fee Scale.

.14J. Charity Care and Sliding Fee Scale. Each applicant for hospice services shall have a written policy for the provision of charity care for uninsured and under-insured patients to promote access to hospice services regardless of an individual's ability to pay. The policy shall include provisions for, at a minimum, the following:

(1) Provide documentation of financial estimates of the amount of charity care that it intends to provide annually;

Capital Caring's Charity Care and Sliding Fee Scale Policy states: "Capital Hospice establishes a targeted threshold for charity care as part of its annual financial plan which is approved by the board of trustees. Capital Hospice is committed to funding charity care, and has established an active fundraising campaign to support this mission." (DI#33) Based on Capital Caring's audited financial statements, it provided an average of $2,127,044 in charity care for each of the years 2010-2012. The applicant projects an average of $2,382,141 annually in charity care from 2014-2016. This is 3% of net patient service revenue. The operating budget submitted in Capital Caring's application for the inpatient hospice presented an annual charity care allocation that averaged 3.23% of net patient revenues.

(2) Provide documentation of a written policy for the provision of complete and partial charity care for indigent and other persons unable to pay for services;

Capital Caring's Charity Care and Sliding Fee Scale Policy states that "Patients who have a family income at or below 200% of the federal poverty guidelines are eligible for charity care," and at that income level pay nothing. (DI#33)

(3) Provide documentation of a written policy for the provision of sliding fee scales for clients unable to bear the full cost of services;

Capital Caring has submitted a Charity Care and Sliding Fee Scale Policy. It states that "Patients who have a family income at or below 200% of the federal poverty guidelines are eligible for charity care. A sliding fee scale is used to determine payment rates for patients who have a family income between 200% and 400% of the federal poverty guidelines." (DI#33)

(4) Provide a written copy of its charity care and sliding fee scale policies to each client before services are begun;

(5) Provide documentation that an individual notice of charity care is provided to each person who seeks services in the hospice program; and

Capital Caring Charity Care and Sliding Fee Scale Policy states that: "Capital Hospice ensures that all patients and families are aware of its charity care policy by providing an individual notice of charity care to each person who seeks services in the hospice program." (DI#33)

(6) Make a determination of probable eligibility for charity care and/or reduced fees within two business days of the client's initial request.

Capital Caring Charity Care and Sliding Fee Scale Policy states that: "Capital Hospice will make a determination of probable eligibility for charity care and/or reduced fees within two business days of the client's initial request." (DI#33)

I find that the applicant meets the Charity Care and Sliding Fee Scale standard.

.14K. Quality.

.14K. Quality. An applicant shall document ongoing compliance with all federal and state quality of care standards.

Capital Caring is licensed in Maryland, District of Columbia, and Virginia. The organization is Medicare-certified and CHAP-accredited (Community Health Accreditation Program). (DI#16)

I find that the applicant meets this standard.

.14L. Linkages with Other Service Providers.

(1) An applicant shall identify how inpatient care will be provided to patients, either directly, or through a contract with an inpatient provider that ensures continuity of patient care.

Capital Caring stated that it has links with a number of hospitals, but that, in the event of an emergency or discontinuance of hospital care, a patient would be transported by ambulance to Doctor's Community Hospital, the nearest general hospital, located 2.1 miles from the proposed facility site. (DI# 7)

I find that the applicant meets this standard.

(2) An applicant shall agree to document, before licensure, that it has established links with hospitals, nursing homes, home health agencies, assisted living providers, Adult Evaluation and Review Services (AERS), Senior Information and Assistance, adult day care programs, the local Department of Social Services, and home delivered meal programs located within its proposed service area.

The applicant provided the following list of linkage organizations. (DI#16)

Hospitals • Prince George's Hospital Center • Laurel Regional Hospital • Southern Maryland Hospital Center • Washington Adventist Hospital • Bethesda Naval Hospital* • Doctor's Community Hospital	**Nursing Homes** • Crescent Cities • Villa Rosa • Larkin Chase • Collington • Fort Washington • Bradford Oaks • Patuxent Health & Rehab • Clinton Nursing Home & Rehab • NMS St. Thomas Moore
Assisted Living Providers • Residence on Greenbelt • Collington • Independence Court • Heartfield of Bowie • Golden Touch • Shamrock • Adelphi House • Malta House • Rita's Heavenly Assisted Living	**Residential Service Agencies** • Distinctive • Visiting Angels • Home Instead • Family and Nursing • Prestige Home Health
County Senior Service Agencies • Area Agency on Aging • Prince George's Health Coalition • Prince George's Senior Networking Group	**Home Meal Programs** • Food and Friends

* *Under the Base Realignment and Closure Commission (BRACC), Bethesda Naval Hospital has been renamed. It is now called Walter Reed National Military Medical Center.*

I find that the applicant meets this standard.

.14M. Respite Care.

.14M. Respite Care. An applicant shall document its system for providing respite care for the family and other caregivers of clients.

The applicant responded that this project is "intended to provide the general inpatient level of care rather than the respite level of care," and that Capital Caring has established relationships with several nursing homes in Prince George's County to provide respite care for

patients and families in need. Those nursing homes are: Crescent Cities Center in Riverdale; Genesis Larkin Chase in Bowie; Collington Center in Mitchellville; Fort Washington Health and Rehabilitation Center in Ft. Washington; and Bradford Oaks Nursing and Rehabilitation Center in Clinton. (DI#7)

I find that applicant meets this standard.

.14N. Public Education Programs.

.14N. Public Education Programs. An applicant shall document its plan to provide public education programs designed to increase awareness and consciousness of the needs of dying people and their caregivers.

The applicant provided a policy and procedure document that reflects a commitment to public education about hospice and palliative care realized by its: participation in community activities and events; service on committees and boards; speakers' bureau activities; and periodic community needs assessments. The applicant also provided a schedule of speaking events and notice of two 6-week "Caring Conversations: Support for Caregivers" programs that were to take place in Prince George's County in the fall of 2013. (DI#16)

I find that the applicant meets this standard.

.14O. Patients' Rights.

.14O. Patients' Rights. An applicant shall document its compliance with the patients' rights requirements of COMAR 10.07.21.21.

Capital Caring has a policy (Policy Number: AD.P15) and also prints and disseminates a notice of patients' rights and responsibilities whose provisions comply with COMAR 10.07.21.21. (DI#7 and DI#16)

I find that the applicant meets this standard.

B. COMAR 10.24.01.08G(3)(b) NEED

COMAR 10.24.01.08G(3)(b) Need. The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

Introduction

Neither the hospice regulations under which this application is being reviewed nor the 2013 Hospice Chapter provides a need methodology or specific standards for needs assessment with respect to inpatient hospice bed capacity. Currently only nine of 27 general hospices operating in Maryland provide inpatient care directly through their own facilities within the State; the others provide this required service through relationships with hospitals and nursing

homes that accommodate their enrolled hospice patients when inpatient admission is necessary. In such cases, the hospice coordinates with the admitting facility in caring for the patients, with hospice personnel providing some of the services needed by the patient during the inpatient stay. Empirical data shows that hospices that operate their own units have a higher ratio of inpatients to total patients than hospices that do not operate their own inpatient facilities.[2]

Capital Caring built its initial case on several factors, as summarized below. (DI#2)

- **Prince George's County's population is large, and its elderly population is growing rapidly.** The applicant cites the Maryland Department of Planning's May 2012 report to point out that Prince George's County is the second most populous in Maryland (863,420 in 2010) and is projected to grow to 882,200 in 2015, an increase of approximately 2.2% over a 5-year period. (DI#2)

  Capital Caring also points out that the county has a large and rapidly growing senior population, with 81,510 persons aged 65+ in 2010, projected to be 103,950 in 2015, a 27.5% increase over 5 years. The applicant draws the conclusion that the size and growth of the elderly population indicates the need for a readily accessible full complement of services for advanced illness care in the community.

- **The residents of Prince George's County do not have access to general inpatient hospice care in a dedicated facility within the county.** The applicant refers to what, at the time of its application, was the MHCC staff's draft replacement Hospice Chapter which cited net need for hospice services and stated that: "[a]s the overall demand for hospice services in the county exceeds the volume threshold, the need for a dedicated facility and staff trained in the intensive symptom management for hospice patients also is rising." (DI#2)

- **Contract beds for inpatient care are not a substitute for a dedicated hospice inpatient facility.** Like many hospice organizations, the applicant has contracted with area hospitals for general inpatient beds. In Maryland, Capital Caring provides general inpatient care by contracting with three hospitals – Prince George's Hospital Center in Cheverly, Laurel Regional Hospital in Laurel, and MedStar Southern Maryland Hospital Center in Clinton. It states, however, that:

  > While the arrangement creates a clinical setting for the intensive management of symptoms…there are a number of flaws in this approach… acute care physicians and nurses are not trained in the palliative care specialty. While the hospice provider remains involved with care management, it is not able to ensure that the hospice plan of care is

[2] "Hospices that used inpatient units provided GIP to 35 percent of their beneficiaries. In contrast, hospices that did not use inpatient units and provided GIP in hospitals or SNFs did so for 12 percent of their beneficiaries."- DHHS OIG Report: Medicare Hospice: Use of General Inpatient Care, OEI-02-10-00490. May 3, 2013

administered consistently and in a way that focuses intensely on patient comfort. Additionally, the hospice interdisciplinary care model which includes chaplain, social worker, and hospice volunteers is not easily deployed in the hospital or nursing home settings...the hospice patient and family does not gain the full benefit of the general inpatient setting...which is designed to surround them with an integrated team of caregivers who specialize in intensive symptom management for advanced illness. (DI#2)

- **Access to general inpatient hospice requires proximity.** The applicant states that "[a]necdotally, Capital Caring staff regularly report that the distance and travel time from Prince George's County to [its] Halquist Memorial Inpatient Center in Arlington, VA are barriers to care." To illustrate this point, the applicant included data on admissions by Capital Caring in the D.C. metropolitan area. Indeed, 50% of Halquist's patients came from Capital Caring's Arlington and Alexandria regional offices, and just 7% from the Largo office.[3]

During the course of the completeness review, MHCC staff asked questions aimed at eliciting a more quantified approach to needs assessment by the applicant. Given that neither the applicable nor the replacement Hospice Chapter contains a need methodology for inpatient hospice beds, this review criterion requires an applicant to demonstrate "unmet needs of the population to be served, and establish ... that the proposed project meets those needs." it is the applicant's responsibility to build a rational case. The applicant responded by presenting two alternative approaches to projecting need. As described by the applicant, the methodologies drew upon factors including "the population of Prince George's County, hospice utilization data, the experience of other Maryland general inpatient hospices, and the Commission's decision, in 2012, to approve a six-bed inpatient unit for Hospice of Queen Anne's." (DI#16) More details regarding Capital Caring's methodology are presented below.

Methodology

The analyses Capital Caring presented were premised on two factors: (1) defining a use rate; and (2) defining the population to whom that use rate would be applied. The applicant's assumptions regarding these factors are summarized below.

Use rate

The applicant presented two different approaches to defining a use rate for GIP hospice services in Prince George's County.

1. "Industry norms": The applicant cites "industry norms" as indicating that one inpatient hospice bed is needed for every 15-20 hospice patients in care as measured by average daily census. The source of this "norm" is a phone call with Wayne Barth,

[3] I note that the relevance of this data is incomplete without corresponding population data.

Controller with Gilchrist Hospice, in which he shared Gilchrist's 2013 year-to-date experience (through August, 2013) showing:

- A total hospice patient average daily census of 542 for Gilchrist;
- 46 hospice beds available for Gilchrist patients or one bed per 11.8 total hospice patients;
- An inpatient average daily census of 40 at Gilchrist or one inpatient per 13.55 total hospice patients.

2. Experience in Maryland and prior MHCC decisions: The applicant also drew on the Commission's CON decision regarding the Hospice of Queen Anne's, (HQA) stating that HQA showed that 40% of hospice patients meet Medicare eligibility requirements for GIP services. The applicant suggests that this provides a rationale for projecting bed need based on 40% of the annual hospice patients it serves.[4]

Population to be served

Capital Caring defined its base population for application of use rates in two ways:

1. State Health Plan: The applicant cited the need for hospice services as presented in COMAR 10.24.13: Supplement Tables showing 4,946 projected deaths in Prince George's County in 2016 and a Gross Hospice Need of 2,235.

2. Internally-generated need: According to its submission, Capital Caring served 729 Prince George's patients in 2012 (DI#16). [5]

The Applicant's Need Projections

a) Population-based approach using State Health Plan (SHP) to define the population, and using "industry experience" to set the use rate

The applicant presented an analysis that was developed using the Commission's estimate of projected deaths in Prince George's County in 2016 and what the applicant describes as "the widely acknowledged industry benchmark" of one general inpatient bed per 15-20 home care patients.

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[4] I note that this is a misinterpretation of what Hospice of Queen Anne's (HQA) actually said during the review of its CON application to establish as a GIP facility what had previously been its residential facility. HQA noted that approximately 40% of the patients in its residential facility met the Medicare requirements for general inpatient care. Staff analysis in that review showed that those Maryland hospices operating their own GIP units experienced a ratio of inpatients to total patients of 1:2.6 (38%). Staff analysis conducted during the review of Hospice of the Chesapeake's application to establish a GIP facility revealed that Maryland hospices that have their own GIP units experienced a ratio of inpatients to total patients in 2010 of one inpatient per 2.7 total patients, approximated by this applicant as 38% of total patients.

[5] The MHCC Hospice Survey shows that the number actually reported was 745.

Table 1: Population-Based Need Projection		
Data points		**Source or Derivation**
Total Projected Deaths, 2016:	4,946	COMAR 10.24.13:Supplement Tables, Table 8
Gross Hospice Need (Target rate =0.45), 2016:	2,235	COMAR 10.24.13:Supplement Tables, Table 8
Average Length of Stay:	57 days	COMAR 10.24.13:Supplement Tables, Table 3
Hospice Patient Days:	127,395	Hospice need (2) multiplied by 57 day ALOS (3)
Average Daily Census:	349	Hospice patient days/365 days
Translating General Hospice Need to GIP Need		**Explanation**
Assuming 1 Inpatient Bed / 15 Hospice Patients: **23 beds needed**		# beds needed to serve all inpatient need assuming that 1 in 15 patients among the average daily census needs GIP care
Assuming 1 Inpatient Bed / 20 Hospice Patients: **17 beds needed**		# beds needed to serve all inpatient need assuming that 1 in 20 patients among the average daily census needs GIP care

The applicant notes that a 7-bed unit to serve a daily census of 349 hospice patients computes to a ratio of just one GIP bed for every 50 hospice patients, well below the "industry benchmark," and thus would only partially address need for inpatient hospice care in Prince George's County.

b) Need as projected by percent of the agency's total annual patients that will need GIP care

Capital Caring also projected need based on what it cites as a previously-accepted rationale in the HQA CON application in which HQA projected that 40% of patients seeking hospice care would meet the requirement for general inpatient care and this was accepted by MHCC.[6] Based entirely on its internally-generated need as experienced in 2012, the applicant has produced the following need calculation.

Table 2: Capital Caring GIP Bed Need -- Largo Region	
Capital Caring Hospice Patients, 2012:	729
Assuming that 40% are GIP Eligible Yields Need of :	292
@ Average Length of Stay of 8 days, patient days =	2,333
Yielding an Average Daily Census of:	6.4
Bed Need @ a Target Occupancy of 90%:	7.1

The applicant concluded, based on this calculation, that the population of Prince George's county in 2012 needed seven GIP beds.

[6] As I noted earlier, this is not what HQA actually said in its CON application; the MHCC did not approve that project on the basis of the rationale attributed by Capital Caring.

Reviewer's Analysis and Findings

Prince George's County is a Maryland jurisdiction with a relatively low hospice use rate (22% of Medicare beneficiary deaths), well below the national use rate (45%). This calls the applicant's use of the gross general hospice need count of 2,235 hospice-eligible deaths as part of a needs assessment into question, given that it was derived from the much higher national use rate. However, even if one were to substitute the Prince George's County "baseline use rate" of 22% for the "target rate" (45%) in 2016, the Medicare population in Prince George's County would still be projected to generate demand for 9.4 beds at an average annual occupancy rate of 90%, if one accepts the higher end of Capital Caring's ratio of 1 bed per average daily census of 20 total hospice patients, as follows:

- 4,946 projected Medicare beneficiary deaths in the Prince George's County population (2016) X 22% hospice use rate = 1.088 hospice patient deaths
- 1,088 hospice patient deaths X 57 day ALOS = 62,023 hospice patient days
- 62,023 hospice patient days / 365 days in the year = an average daily census (ADC) of 170 hospice patients
- 170 hospice patients X .05 ratio of hospice inpatient ADC to total hospice patient ADC = 8.5 hospice inpatient average daily census
- 8.5 hospice inpatient average daily census @ 90% average annual occupancy = need for 9.4 hospice beds

Applying the alternate approach of projecting demand based upon a given percent of total patients served by the agency in a year results in my finding need for this project. In Table 3 below, I have calculated a range of need estimates based on Capital Caring's "internal need" starting point of total hospice patients in 2012. Scenarios were low, mid, or high, based on varying the percent of hospice patients who would need GIP care and the assumed length of stay.

Table 3: Capital Caring GIP Bed Need -- Largo Region

Factor	Value	Notes and/or comments
Hospice patients served by Capital Caring	745	As reported in 2012 MHCC Hospice Survey
Proportion of hospice patients needing GIP care	23% - 27.4%	• Nationally, in 2012, 27.4% of hospice patients received care in an inpatient facility* • In 2011, 23% of Medicare hospice beneficiaries received in patient care**
Average length of inpatient stay	7 -8 days	Applicant assumed an ALOS of 8 days; MHCC analysis in 2012 HOC review assumed 7 days; Medicare study found that "...one third of beneficiaries' GIP stays exceeded 5 days with 11 percent lasting 10 days or more."

* National Hospice and Palliative Care Organization's Facts and Figures – Hospice Care in America, 2013 Edition

** Memorandum Report: *Medicare Hospice: Use of General Inpatient Care*, OEI-02-10-00490

As shown immediately below, at 2012 volumes, a GIP census between 4.0 and 6.2 can be projected using these values.

Low end estimate

# of annual hospice patients served by Capital Caring	% needing GIP care	Average length of stay	Patient days	Average census
745	28%	7	1,460	4.0

Mid-range estimate

# of annual hospice patients served by Capital Caring	% needing GIP care	Average length of stay	Patient days	Average census
745	33%	7.5	1,844	5.05

High end estimate

# of annual hospice patients served by Capital Caring	% needing GIP care	Average length of stay	Patient days	Average census
745	38%	8	2,265	6.2

Given that recent Maryland experience in GIP utilization among hospices operating their own GIP facilities can be characterized as 38% of total patients, the high-end estimate appears to be directly applicable in this case. I believe that it is also important to consider the significant year-to-year growth in patient volume that Capital Caring has experienced: a 16% increase in 2011 over 2010, and a 28% increase in 2012 over 2011. Thus, I conclude that Capital Caring is likely to continue to increase the number of hospice patients it serves and, therefore, will likely generate GIP patients from a larger number of annual hospice patients served than the 745 used in my calculations.

I find that the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project is sized to meet those needs.

C. COMAR 10.24.01.08G(3)(c) AVAILABILITY OF MORE COST-EFFECTIVE ALTERNATIVES

COMAR 10.24.01.08G(3)(c) Availability of More Cost-Effective Alternatives. The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

The applicant asserted that the GIP level of care is the most cost-effective method of care for a hospice patient whose symptoms cannot be effectively managed in the home setting, contrasting it with the cost of managing those symptoms in an acute care hospital, given that "[t]he focus on symptom management eliminates the high cost of most advanced diagnostic testing and surgical interventions."

In support of this premise, Capital Caring presented data from the *Maryland Hospital Pricing Guide – Fiscal Year 2012* published by the Maryland Health Services Cost Review Commission showing that the average daily charge associated with an inpatient hospital day is approximately three times the Capital Caring charge of $900/day (Medicare pays $716). The applicant posited that, once its Prince George's inpatient hospice facility is available, fewer hospice-eligible patients would be dying as general acute hospital patients in the much more expensive general acute care hospital setting. Capital Caring noted that staff in its Largo office stated that patients were reluctant to enter inpatient care in its facilities in Virginia because of the distances involved.

Capital Caring also stated that the availability of GIP care saved money by reducing reliance on hospital emergency rooms to manage symptoms. In support of this assertion, it presented data showing that patients served from its Arlington regional office (with nearby GIP access at its Halquist Memorial Inpatient Center) had significantly fewer emergency department visits than did patients associated with its Largo office, significantly farther away from Halquist (see table immediately below). (DI#2 and DI#11)

Capital Caring Locations	**Total Hospice Patients 2012**	**ER Visits 2012**	**ER Visits/Patient 2012**
Largo, Maryland	226	74	.327
Arlington, Virginia	872	52	.059

I find that the applicant has demonstrated the cost-effectiveness of hospice-eligible patients being cared for in general inpatient hospice care and that this project will likely reduce the number of hospice-eligible patients spending their final days in the more expensive acute general hospital inpatient setting. The applicant has presented a cost-effective proposal for meeting the need for inpatient hospice care in Prince George's County.

D. COMAR 10.24.01.08G(3)(d) VIABILITY OF THE PROPOSAL

COMAR 10.24.01.08G(3)(d) Viability of the Proposal. The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

The applicant's project cost estimate is as follows:

Project Budget	
Capital costs	
Renovations	$283,826
Fixed equipment	24,934
Architect/Engineering fees	67,900
Permits	8,300
SUBTOTAL	$384,960
Other capital costs	
Major movable equipment	$28,383
Minor movable equipment	5,000
Contingencies	20,000
Other	-- --
TOTAL CURRENT CAPITAL COSTS	$438,343
Non-current capital cost	
Interest	-- --
Inflation	-- --
TOTAL PROPOSED CAPITAL COSTS	$438,343
Financing costs and other cash requirements	
Legal fees (CON-related)	$20,000
TOTAL USES OF FUNDS	$458,343

Availability of resources to implement the project

As shown in the immediately preceding table, the estimated total project cost is $458,343. (DI#2) Capital Caring intends to fund the project from unrestricted liquid assets. (DI#11) Audited financial statements for CY 2012, provided by Capital Caring, identified a substantial surplus of total assets ($70,823,721) over liabilities ($16,021,614) with sufficient cash available to carry through on this plan.

Availability of Resources Necessary to Sustain the Project

In addition to the substantial assets described above, financial information submitted by Capital Caring shows its entire hospice operated profitably in the years reported (2011 and 2012). (DI#2, audited financial statements).

	2011	2012
Revenue		
Net patient service revenue	$61,063,288	$67,226,276
Other operating revenue	406,787	412,734
Net operating revenue	61,470,075	67,639,010
Total operating expenses	$60,631,205	$65,776,470
Income from operations	838,870	1,862,540
Non-operating income	1,566,740	3,306,125
Subtotal	2,405,610	5,168,665
Income taxes	4,613	4,177
Net income	**$2,400,997**	**$5,164,488**

Key volume and financial data points from the operating projections for the Residence at Greenbelt are excerpted below. A modest net gain is projected. (DI#11, Table 4)

	2014*	2015	2016
Patient days	1,438	2,190	2,196
Occupancy	67%	86%	86%
Net patient service revenue	$908,040	$1,382,899	$1,386,687
Expenses	$1,065,019	$1,315,954	$1,316,442
Charity Care	$94,765	$144,323	$144,718
Gain (Loss)	($156,979)	$66,945	$70,245

* assumes ten months of operation

The total annual expenses associated with this project are about 2% of Capital Caring's total 2012 expenses. The assumptions made by Capital Caring in its financial projections for the operation of the hospice facility are reasonable.

I find that the proposed project is viable and financially feasible. The applicant has demonstrated community support for the project from the health care sector, the faith community, and the Prince George's County government.

E. COMAR 10.24.01.08G(3)(e) COMPLIANCE WITH CONDITIONS OF PREVIOUS CERTIFICATES OF NEED

COMAR 10.24.01.08G(3)(e) Compliance with Conditions of Previous Certificates of Need. An applicant shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.

Capital Caring has not previously applied for a CON.

F. COMAR 10.24.01.08G(3)(f) IMPACT ON EXISTING PROVIDERS AND THE HEALTH CARE DELIVERY SYSTEM

COMAR 10.24.01.08G(3)(f) Impact on Existing Providers and the Health Care Delivery System. An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

Applicant's Response

Capital Caring posits that the proposed project will have a favorable impact on hospitals, nursing homes, and assisted living facilities in Prince George's County by providing access to a type of hospice care that is not currently available in the jurisdiction. Among the benefits identified for hospitals is a decrease in readmissions and in having emergent symptoms managed through the proposed project rather than in hospital emergency departments. In addition to these benefits, the applicant asserts that the direct financial impact on the hospitals with which it has contracted to use beds for hospice care beds would be insignificant, as the revenue loss from the contracted beds would be a miniscule portion of the hospitals' overall operational revenue. The applicant states that many hospitals prefer not to offer hospice contracts for inpatient care service, as their limited bed capacity is better used for acute care.

Nursing homes also offer their beds to Capital Caring patients on a contract basis, receiving reimbursement of approximately $537.00 per day (75% of the Medicare rate of $716). Although Capital Caring trains nursing home staff in hospice care as part of its contractual obligation, the applicant points out that delivering GIP care in the nursing home setting is less than optimal, as staff turnover in the nursing home setting creates a gap in the continuity of care and the knowledge base of the caregiver team.

Finally, the applicant asserts that since the proposed project involves only seven beds, its impact on occupancy for hospitals and nursing homes in Prince George's County, and general inpatient hospice care providers outside of Prince George's County, is minimal. (DI#16)

Interested Party Comments (DI#22)

Hospice of the Chesapeake believes that it would be adversely affected by an approval of Capital Caring's proposed inpatient unit in Lanham. HOC states that its March 2012 CON application for a 14-bed GIP unit was based on the expanding needs of the hospice patient populations in both Anne Arundel and Prince George's Counties, and that it relied upon access to a continuing market among the hospice patient population in northern Prince George's County.

The interested party states that Capital Caring's proposed inpatient unit targets that precise area, thereby undermining HOC's planning and expectations. HOC claims that approval of the Capital Caring application will have a significant impact on its expected ability to draw upon Prince George's County residents to support its approved GIP. It states, that "[t]he

geographic area, as well as the physical location of Capital Caring's inpatient unit (Lanham), falls squarely in the area upon which Hospice of the Chesapeake relied in making its projections."

HOC references data presented in the Capital Caring application to show that it has a significant hospice patient base in Prince George's County. Citing Attachment E, page 2 of Capital Caring's CON Application, it points out that HOC served 449 patients compared to Capital Caring's 581 in 2011, stating, "As the numbers demonstrate, Capital Caring and Hospice of the Chesapeake are the two largest hospice providers serving the Prince George's County community."

HOC points out that it is "based exclusively in Maryland and focuses all of its resources on serving residents in Maryland based in the Anne Arundel and Prince George's communities," in contrast with Capital Caring, which also serves patients in the District of Columbia and Virginia. HOC says that its project was "premised upon the fact that no dedicated General Inpatient Unit providing hospice care existed in Prince George's County," and that its "volume and revenue expense projections were described and based upon the service area as it existed at the time."

Furthermore, HOC faults the applicant for failing to adequately consider Hospice of the Chesapeake's approved CON, as required in COMAR 10.24.01.08G(3)(f) Impact on Existing Providers, under which Capital Caring must "provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region." HOC points out that the original Capital Caring application failed to address this and did so only after MHCC staff pursued the issue in completeness questions.

HOC finds the subsequent response by Capital Caring to be wanting, questioning the applicant's failure to even acknowledge the recent approval of HOC's proposal and its assertion that the impact of a project involving "only 7 beds" would be "very minimal." Hospice of the Chesapeake believes that it "will likely lose a significant portion of its revenue and potential referrals in the Prince George's County area that is north of route 50," and that "Capital Caring has failed to analyze this impact as required."

Applicant's Response to Interested Party's Comments (DI#23)

In its response, Capital Caring asserted that the impact of its proposed project on HOC will be insignificant, for the following reasons:

1. The Hospice of the Chesapeake project relied on minimal utilization of patients from Prince George's County;
2. The Hospice of the Chesapeake project relied on internal demand, *i.e.*, patients already admitted to Hospice of the Chesapeake; and
3. Prince George's County is very large in both geography and population and does not have an inpatient hospice, and Hospice of the Chesapeake will not have sufficient capacity to serve all of Prince George's County.

Capital Caring argues that HOC's stated concerns are not sufficient to demonstrate that approval of its application would have an adverse impact on Hospice of the Chesapeake's CON-approved project, while emphasizing the merits of its proposal, as summarized below.

- **Capital Caring proposes to serve the residents of Prince George's County with a facility that will be located in Prince George's County, with more convenient access.** Prince George's County has the second-largest population in Maryland, and does not have a freestanding GIP hospice care facility located within the county. The applicant asserts that residents need and should have that level of care available, and that HOC's planned facility in Pasadena does not fulfill the objective of providing community-centered care because of its location.

The applicant contrasts its location in Lanham with HOC's Pasadena location, stating that Lanham is easily accessible from Route 495 and Route 295, while HOC's Pasadena location would impose excessive drive time for most residents of Prince George's County. In addition, it asserts that its proposed facility offers ready access to multiple modes of public transportation.

Table 4

Prince George's Population Centers	Drive time (Minutes) to CC Lanham Location	Drive time (Minutes) to HOC Pasadena Location
Laurel	20	30
Fort Washington	33	62
Hyattsville	17	42
Clinton	20	47
Lanham	--- ---	35

Source: Capital Caring Response to Interested Party comments (DI#23)

- **The applicant states that its census in the region serving Prince George's County (Largo office) is sufficient to support the proposed project.** Citing a "40% eligibility assumption endorsed by the Maryland Health Commission in (its) review of the Queen Anne County application" the applicant claims that a seven-bed unit is justified for Capital Caring's patients alone. (See Table 2 for this calculation.)

From this the applicant draws the conclusion that its "proposed 7-bed inpatient unit will not impact Hospice of Chesapeake as it is not intended to detract from their census, or the census of any other hospice provider serving the residents of Prince George's County."

- **The applicant states that HOC's CON application showed just 21% of the projected GIP patient days coming from Prince George's County.** Capital Caring points out that Table 6 of the HOC application identifies an average daily census of 3.8 Prince George's County patients, and states that, while "that census might be appropriate for Hospice of the Chesapeake's service delivery continuum and need, it does not anticipate or come close to meeting the full scope of services needed to support the residents of Prince George's County...[and, therefore, the applicant's] proposed 7-bed unit will not adversely impact Hospice of the Chesapeake and its planned facility in Pasadena."

- **The applicant is proposing to locate a GIP in the County that the draft State Health Plan identified as having significant need, while HOC's project is to be located in an area that is not identified as a shortage area for hospice care.** Capital Caring notes that, although HOC's service area includes Prince George's County, HOC "is not proposing to provide general inpatient care in the geographic area with the larger population, and therefore, the more significant need. Capital Caring's proposed 7-bed unit will provide general inpatient care for the community that has a significant under-served need."
- **Capital Caring asserts that its proposed project is comparatively cost-effective.** The applicant contrasts its project cost with that of HOC:
  - The Capital Caring project involves the renovation of 6,640 square feet in an existing assisted living facility at an estimated project cost of $570,927 ($85.98 per square foot or $81,561 per bed).
  - Hospice of the Chesapeake has been authorized to build a 14,000 square foot GIP facility at a cost of $5,232,072 ($373.72 cost per square foot or in excess of $373,719 per bed).

Reviewer's Analysis and Findings

I find that the interested party's concerns regarding a potential negative impact on its referrals and revenue based in Prince George's County to be overstated, in light of the small size and scope of the Capital Caring project. Any negative impact on HOC is outweighed by the benefits in access to GIP hospice services that Capital Caring's proposed project, centered in Prince George's County, will bring to residents of that jurisdiction.

I arrive at this conclusion for a number of reasons:

1. It is very likely that there will be enough need for inpatient hospice to go around.

- The replacement Hospice Chapter adopted in 2013 shows a significant unmet need for general hospice services in Prince George's County because of its relatively low use rate for this service. While neither the applicable hospice regulations nor the replacement Hospice Chapter has a need methodology for general inpatient hospice beds, the need for general hospice services suggests that there is room for significant growth in hospice use. It appears that more effective education and marketing efforts and the passage of time will lead to greater acceptance of the value of this service by the county's population.
- Hospice usage by the Prince George's County population has indeed grown significantly in recent years – 22.4% between 2008 and 2012 (see Table 5 below), offering the likelihood that both projects will be utilized adequately.
- In their CON applications, both Capital Caring and Hospice of the Chesapeake pointed out that Prince George's County will experience substantial growth in its

population aged 65 and older. HOC wrote that "the 65+ population of Prince George's County is forecast to increase by 50% from 2010 to 2020." [7] Capital Caring noted that Prince George's County had "81,510 (persons) age 65+ in 2010, projected to be 103,950 in 2015, a 27.5% increase over 5 years." It is highly likely that demographics will drive greater demand for hospice services even if use rates for hospice care remain relatively low.

- In responding to the interested party, Capital Caring pointed out that the HOC application "relied on internal demand, *i.e.* patients already 'admitted' to Hospice of the Chesapeake" in projecting need for its GIP. In fact, that observation appears to be accurate, as HOC projects future volume based on historical trends, with projected annual growth of 4% based on national statistics for hospice demand. Indeed, Capital Caring also demonstrated a demand scenario based on its current numbers. Neither hospice relied on shifts in market share to supply patients for its proposed GIP facility.

Table 5: Growth of hospice patients and market share and market share in Prince George's County: Capital Caring and Hospice of the Chesapeake

Agency	2008	2009	2010	2011	2012
Capital Caring	444 (27%)	416 (27%)	502 (29%)	581(32%)	745 (37%)
Hospice of the Chesapeake	441 (27%)	442 (29%)	458 (26%)	449 (25%)	546 (27%)
Total patients	1,648	1,536	1,755	1,822	2,017

Source: MHCC Hospice Survey

2. The impact on census and revenues is unlikely to be substantial.

Even if my conclusion that there will be enough patients to keep both the HOC project in Pasadena and the proposed Capital Caring facility adequately utilized turns out to be off the mark, the impact on HOC is not likely to be unduly negative. HOC's Pasadena facility CON application projected an average daily census from Prince George's County of 3.8 patients out of a total forecasted HOC ADC of 18.1 patients (HOC CON application, p. 24), about 21% of the combined patient census of HOC's Mandrin Inpatient Center[8] and Pasadena sites. I believe it is likely that HOC will be able to replace any Prince George's County demand that it may lose as a result of Capital Caring's project. In addition, it is important to point out that GIP care is a small proportion of a hospice's total business. For instance, in 2012 only about 1.4% of the total patient-days of care provided by HOC were provided in its GIP setting[9]. The financial impact of a somewhat lower average daily census, if that result occurs, is not likely to have an undue negative impact on Hospice of the Chesapeake.

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[7] Hospice of Chesapeake CON application, p.20

[8] Opened in Nov. 2011, Mandrin had an occupancy rate of 69% in 2012; source, MHCC Hospice Survey

[9] 2012 MHCC Hospice Survey

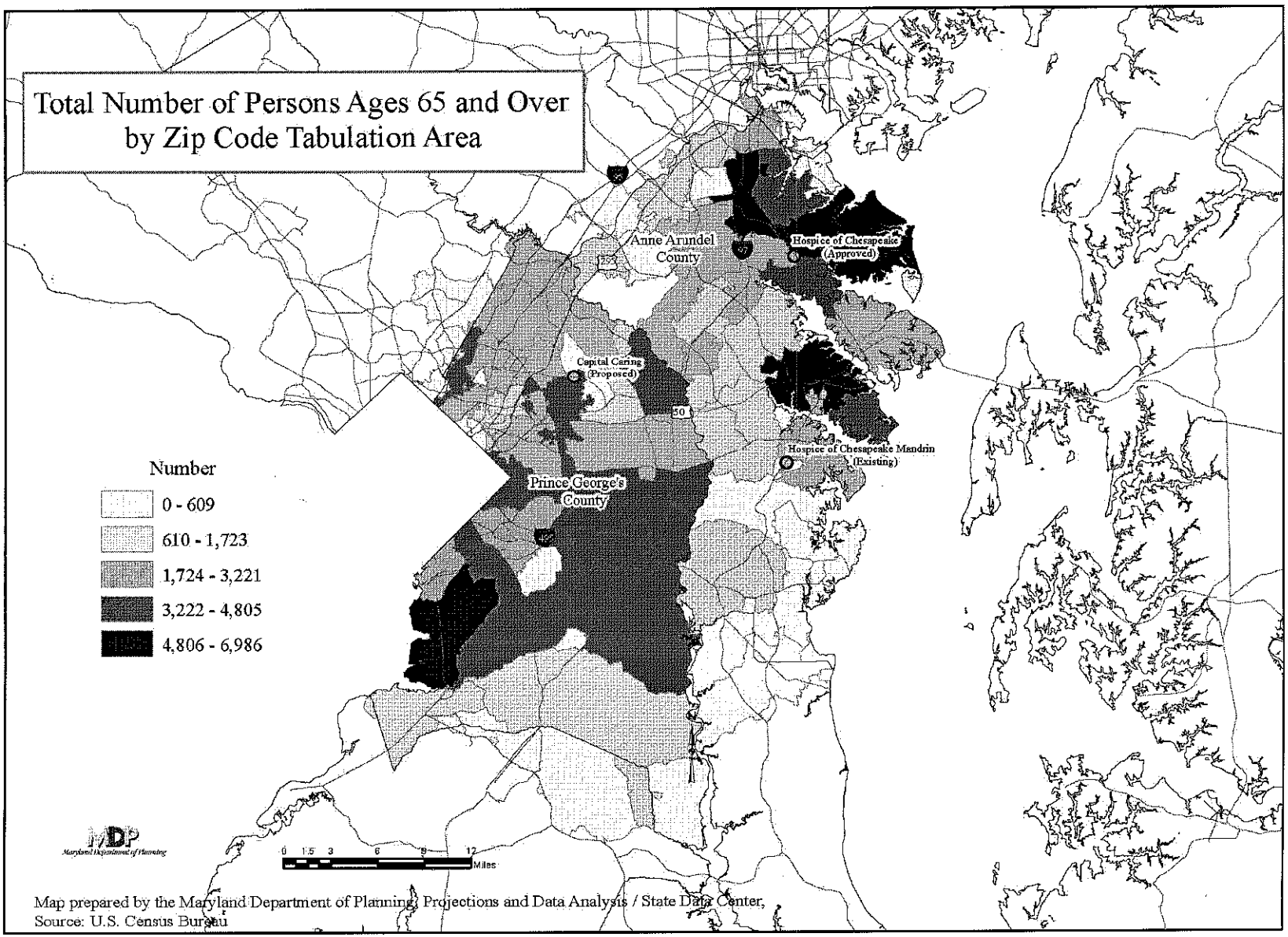
3. Capital Caring's location is more accessible for Prince George's County residents.

Hospice of the Chesapeake listed both Anne Arundel and Prince George's Counties as the service area for its Pasadena project. Its CON application showed that, between 2009 and 2011, 21% of its patients came from Prince George's County. However, HOC's GIP facilities, located in Harwood and Pasadena, are much more easily accessible to Anne Arundel County residents than to Prince George's County residents. The following **Table 6** compares the drive time, in minutes, from a variety of Prince George's County population centers to Hospice of the Chesapeake's currently operating Mandrin Inpatient Care Center, HOC's approved-but-not-yet built GIP facility in Pasadena, and Capital Caring's proposed GIP facility site in Lanham. Capital Caring's site is clearly the most geographically accessible for Prince George's County residents. (See map, next page.)

Table 6: Drive Time, in Minutes, from Prince George's County Population Centers to Three Hospice GIP Facility Sites

Population Center	Drive Time to Proposed CC Lanham Location	Drive Time to Approved HOC Pasadena Location	Drive Time to Existing HOC Harwood Location
Bowie	13	32	26
Laurel	18	26	37
Fort Washington	32	59	43
Hyattsville	16	40	34
Clinton	20	48	30
Greenbelt	9	32	29
New Carrollton	6	36	27

Source: Google Maps


Total Number of Persons Ages 65 and Over
by Zip Code Tabulation Area
Anne Arundel
County
Hospice of Chesapeake
(Approved)
Capital Caring
(Proposed)
Hospice of Chesapeake Mandrin
(Existing)
Prince George's
County
Number
0 - 609
610 - 1,723
1,724 - 3,221
3,222 - 4,805
4,806 - 6,986
MDP
Maryland Department of Planning
0 1.5 3 6 9 12
Miles
Map prepared by the Maryland Department of Planning, Projections and Data Analysis / State Data Center,
Source: U.S. Census Bureau

V. SUMMARY AND RECOMMENDATION

Based on my review of the record, I recommend that the Maryland Health Care Commission approve this project.

The bases of my recommendation are as follows:

The State Health Plan

The applicable section of the State Health Plan for this review is COMAR 10.24.08, the State Health Plan for Facilities and Services: Nursing Home, Home Health Agency, and Hospice Services. The specific standards to be addressed are found at COMAR 10.24.08.14, Hospice Standards. These standards were developed for use in considering proposals to establish new general hospice programs or expand an existing hospice program to one or more additional jurisdiction. As such, they outline what the elements of an acceptable hospice program should be.

This proposed Capital Caring project does not fit either of these project categories. Thus in this review the current SHP serves as a checklist review for a large, established hospice like Capital Caring; its operations would be expected to be currently in compliance with these standards. Thus it was no surprise to find Capital Caring to be substantially in compliance with these standards.

Capital Caring did need to make some revisions to its policies to come into compliance with the standard for Charity Care and Sliding Fee Scale. Specifically: Capital Caring needed to modify its policies so as to routinely provide its charity care and sliding fee scale policies to each client before services are begun – before modifying these policies, it was not providing the required information to all prospective patients, but only to those it determined, through some means, would be potential candidates for financial assistance. Additionally, Capital Caring needed to establish, as routine policy, that it would make a determination of probable eligibility for charity care and/or reduced fee service within two business days of a patient request. It made the necessary policy revisions.

Need

Although the initial application was lacking a strong quantification of need, completeness questions by staff ultimately resulted in a qualitative and quantitative demonstration of need by the applicant of its need case. While this is addressed in detail earlier in this report and recommendation, it can be summarized as follows:

- **Prince George's County's population is large, and its elderly population is growing rapidly.** Prince George's County is the second most populous county in Maryland, and it has a large and rapidly growing senior population which is projected to be 103,950 in 2015. The vast majority of hospice patients are seniors.
- **The residents of Prince George's County do not have access to general inpatient hospice care in a dedicated facility within the county, and effective access to**

general inpatient hospice requires proximity. The proposed site would significantly reduce travel times as compared to alternatives. The applicant stated that "[a]necdotally, hospice staff regularly report that the distance and travel time from Prince George's County to (Capital Caring's) Halquist Memorial Inpatient Center in Arlington, VA are barriers to care." (DI#2) I conclude that the lack of a dedicated inpatient hospice facility in Prince George's County likely results in less inpatient hospice use in the County and, consequently, in more hospice-eligible patients dying as general hospital inpatients.

- **Contract beds for inpatient care are not a substitute for a dedicated hospice inpatient facility.** Although the applicant has contracted with area hospitals and nursing homes for general inpatient beds, it, like previous hospice applicants seeking a CON for inpatient units, has made a compelling case that contracting for beds in an acute care hospital or nursing home is a poor substitute for a setting designed specifically for this purpose and staffed with specially trained and dedicated personnel. In their words: "the hospice patient and family does not gain the full benefit of the general inpatient setting...which is designed to surround them with an integrated team of caregivers (specializing) in intensive symptom management for advanced illness" when this care takes place in a general hospital or nursing home rather than a dedicated hospice facility.
- **Quantifying need.** The applicant and staff research provided data from a variety of sources showing that the use rate of inpatient services among hospice patients ranged from 23% (2011 Medicare study) to 38% (recent experience of Maryland hospices that operate their own GIP facilities). Applying these use rates to Prince George's demographics and Capital Caring's patient base do not indicate that the applicant's and the interested party's planned and existing facilities will create inpatient bed capacity that will exceed the likely need for service generated by their respective service areas.

Cost-Effectiveness and Alternatives

The applicant asserted that the GIP level of care is the most cost-effective method of care for a hospice patient whose symptoms cannot be effectively managed in the home setting, contrasting it with the cost of managing those symptoms for acute general hospital inpatients. Capital Caring also showed that the availability of GIP care saved money by reducing reliance on hospital emergency rooms to manage symptoms.

In addition, the cost of renovating this space in an existing assisted living facility is significantly less than the option of building a new facility.

Viability of the Proposal

I find the project to be viable. The applicant is well-established with a track record of generating a positive bottom line. The modest project cost will be funded out of cash. On an operating basis, the projected pro forma shows a modest positive margin beginning in the second

year of operations. In addition, letters of support from health care providers, the faith community, and county government demonstrate community support.

Impact on Existing Providers and the Health Care Delivery System

I do not believe that there will be an undue negative impact on existing providers, based on my analysis that there will be sufficient demand for general inpatient hospice care to well utilize existing, approved, and proposed capacity.

- The replacement Hospice Chapter adopted in 2013 shows a relatively low use rate and significant unmet need for hospice services in Prince George's County, suggesting that there is room for significant growth in hospice use if more effective education and marketing efforts lead to greater acceptance of the value of this service by the county's population.
- Hospice use by the Prince George's County population has indeed grown significantly in recent years – 22.4% between 2008 and 2012 (see Table 5 below), offering the likelihood that both projects will be utilized adequately.
- Prince George's County will experience substantial growth in its population aged 65 and older. It is highly likely that demographics will drive greater demand for hospice services even if use rates for hospice care remain relatively low.
- As Capital Caring pointed out, HOC's application for its approved inpatient hospice facility "relied on internal demand, i.e. patients already 'admitted' to Hospice of the Chesapeake" in projecting need. Neither hospice relied on shifts in market share to supply patients for its proposed GIP facility. Thus it is still possible that HOC's current market penetration will not change simply because a competitor adds a GIP facility.

MARYLAND HEALTH CARE COMMISSION

APPENDIX 1: Record of the Review

Docket Item #	Description	Date
1	Letter of Intent received from Capital Caring on December 22, 2012. MHCC acknowledged receipt on January 4, 2013.	1/4/13
2	Capital Caring submitted a Certificate of Need application proposing a 7-bed inpatient hospice facility.	6/21/13
3	Commission acknowledged receipt of the application in a letter to Capital Caring.	6/24/13
4	Commission requested publication of notification of receipt of the Capital Caring proposal Washington Times.	6/24/13
5	Request to publish notice of receipt of application in the *Maryland Register.*	6/24/13
6	Receipt of confirmation that the CON application was received by the Prince George's Co. Health Department.	6/21/13
7	MHCC Staff requested additional information from the applicant complete its application on July 8, 2013.	7/8/13
8	Letters of support received from Elizabeth Morton of Laurel Regional Hospital (Advance Care Planning/Quality Improvement) on July 18; Anne White of Gethsemane United Methodist Church (Community Outreach) on July 18; Neal Kursban, President of Family & Nursing Care (private duty home services) on July 19.	Various dates
9	MHCC received certification of publication of the application filing notice from the Washington Times.	7/5/13
10	Request for extension to file completeness information until July 29 granted via email.	7/16/13
11	Additional information provided by applicant.	7/29/13
12	Letter of support from Cherrie Dupree, R.N. of Clinton Nursing and Rehabilitation Center.	8/7/13
13	Second round of completeness/additional information questions sent.	8/12/13
14	Email from Joel Riklin to Cynda Tipple of Capital Caring providing clarification of question in the completeness letter sent on August 16, 2013.	8/16/13
15	Extension granted via email allowing extension until September 16, 2013 to file completeness information.	8/23/13
16	Additional information provided by applicant.	9/16/13
17	MHCC informs Capital Caring that formal start of the review will begin October 4, 2013.	9/23/13
18	Request made to Washington Times on September 23, 2013 to publish notice of formal start of review.	9/23/13
19	Request made to Maryland Register on September 23, 2013 to publish	9/23/13

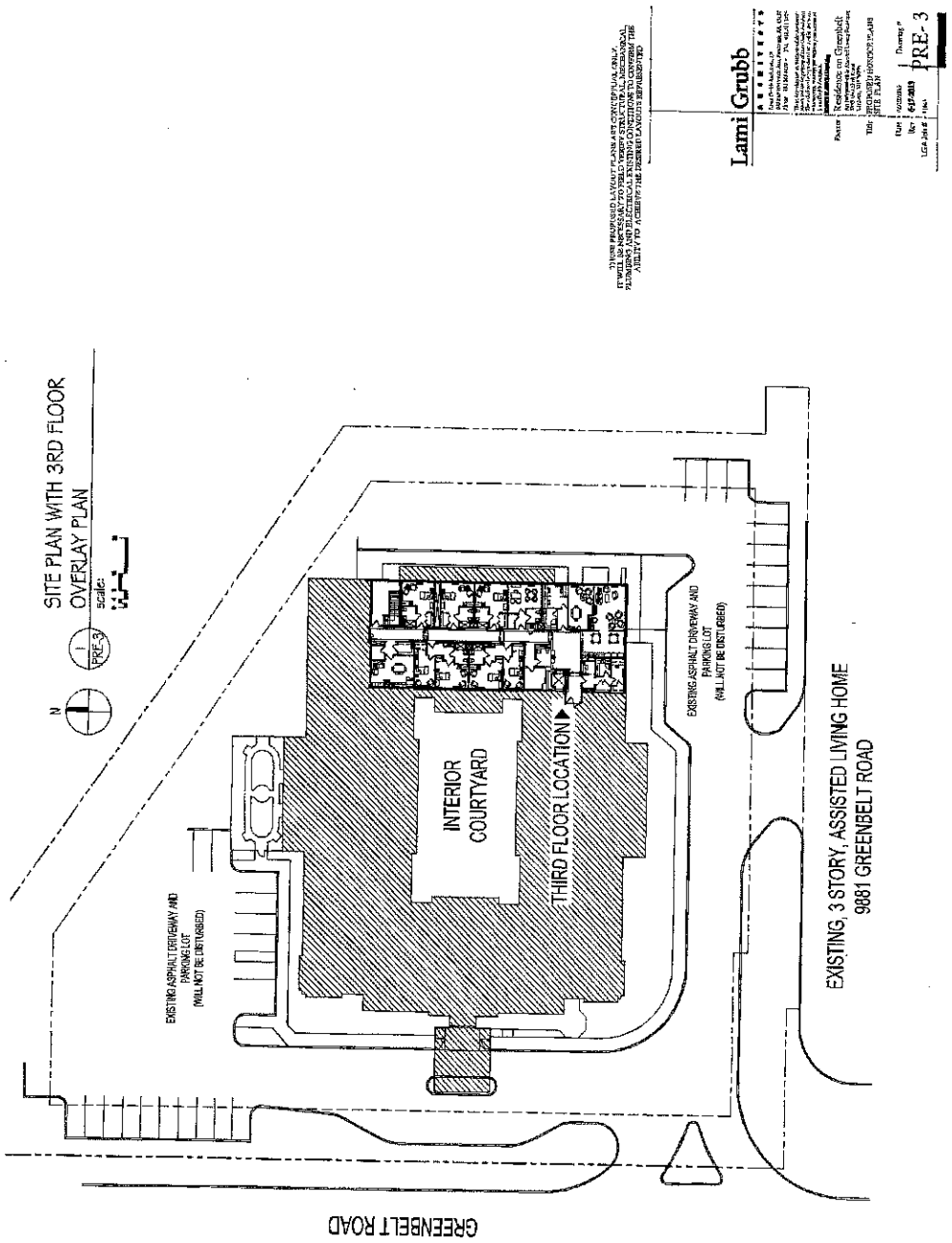
Appendix 1

	notice of formal start of review.	
20	Notice of formal start of review published in the Washington Times on October 2, 2013.	10/2/13
21	Form requesting local health planning comments on the application sent on October 17, 2013.	10/17/13
22	Hospice of Chesapeake files comments and requests interested party status.	11/4/13
23	Capital Caring files response to Hospice of Chesapeake comments.	11/20/13
24	Letter from Commission Reviewer Glenn Schneider to Hospice of Chesapeake confirming interested party status, January 8, 2014	1/8/13
25	Letter from Commission Reviewer Glenn Schneider to Capital Caring requesting additional information.	2/7/14
26	Capital Caring response to Commissioner/Reviewer Schneider – Additional information as requested.	2/13/14
27	Reviewer Schneider letter to Capital Caring with request for revised Charity Care Policies, March 26, 2014.	3/26/14
28	Capital Caring's attorney Carolyn Jacobs stating that applicant will file revised Charity Care policy and requesting expedited review of issues	3/28/14
29	Revised Capital Caring Charity Care and Sliding Fee Scale Policy, received April 15, 2014.	4/15/14
30	Reviewer Schneider letter to Capital Caring advising that the Charity Care Sliding Fee Scale Policy still does not meet the standard and asking if parties want a status conference.	4/17/14
31	E-mail from Hospice of Chesapeake CEO McHale advising MHCC that Hospice of Chesapeake will not request formal status conference	4/21/14
32	E-Mail from Capital Caring advising that Capital Caring does not wish to request formal status conference.	4/21/14
33	Revised Capital Caring Charity Care and Sliding Fee Scale Policy.	4/21/14
34	Reviewer Schneider letter to Capital Caring and Hospice of Chesapeake notifying that Hospice of Chesapeake has until 4/28/14 to respond to Charity Care Issue.	4/22/14

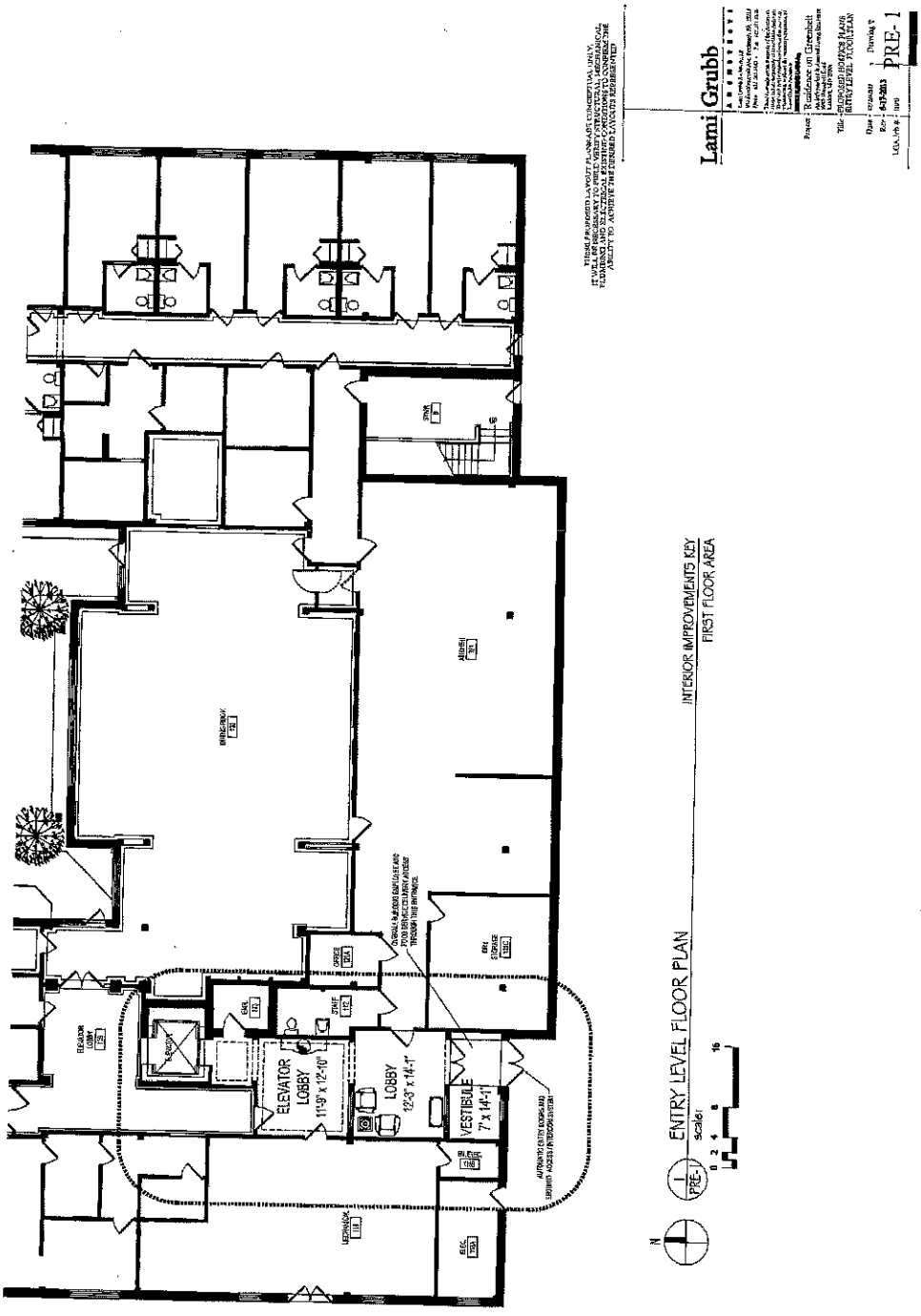
MARYLAND HEALTH CARE COMMISSION

APPENDIX 2: Project Drawings

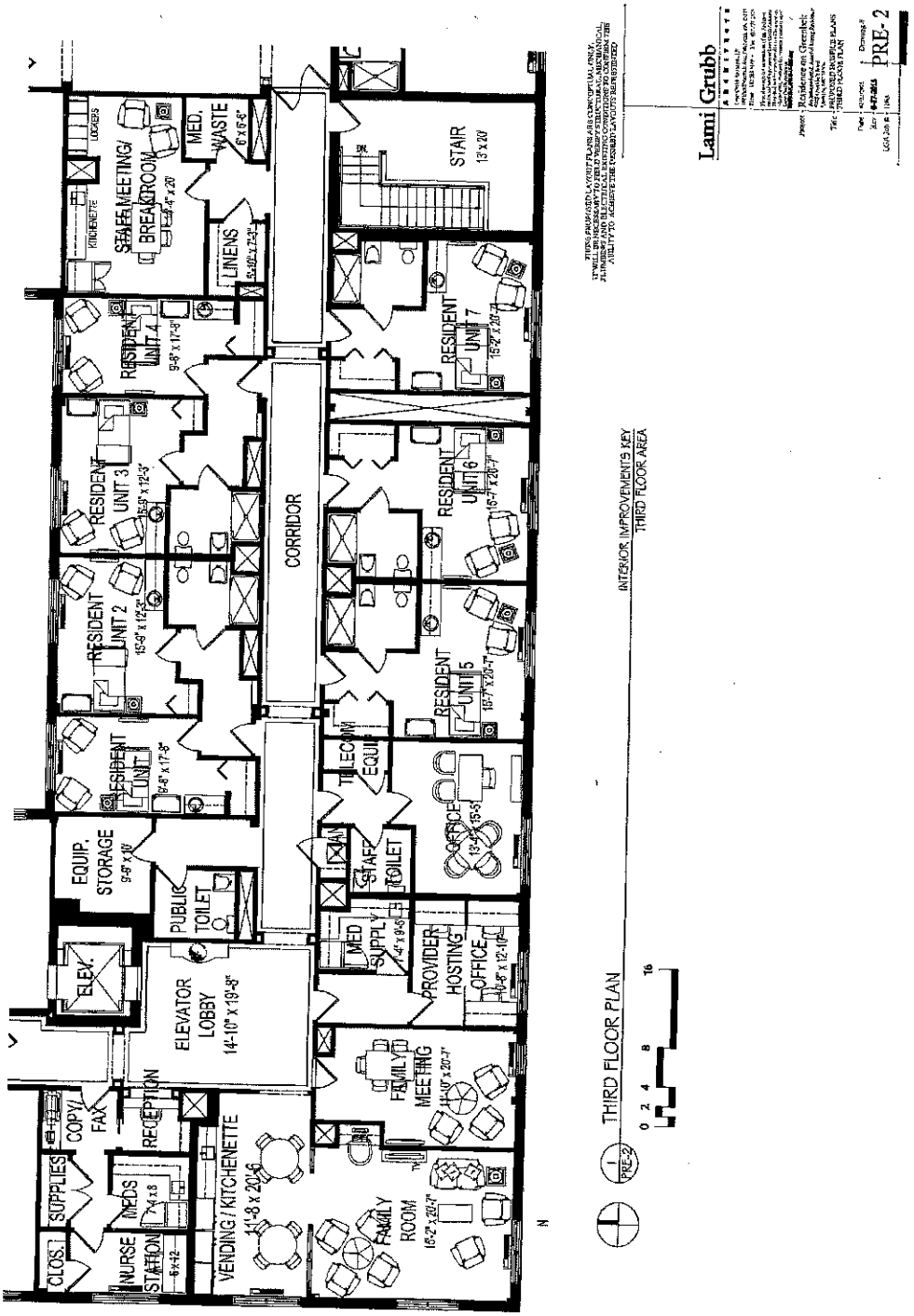
Appendix 2


SITE PLAN WITH 3RD FLOOR OVERLAY PLAN
PRE-3
N
INTERIOR COURTYARD
THIRD FLOOR LOCATION
EXISTING ASPHALT DRIVEWAY AND PARKING LOT (WILL NOT BE DISTURBED)
EXISTING ASPHALT DRIVEWAY AND PARKING LOT (WILL NOT BE DISTURBED)
EXISTING, 3 STORY, ASSISTED LIVING HOME
9881 GREENBELT ROAD
GREENBELT ROAD
Lami Grubb
PRE-3

Appendix 2


ELEVATOR LOBBY 11'-9" x 12'-10"
LOBBY 12'-3" x 14'-1"
VESTIBULE 7' x 14'-1"
ENTRY LEVEL FLOOR PLAN
INTERIOR IMPROVEMENTS KEY
FIRST FLOOR AREA
Lami Grubb
PRE- 1

Appendix 2


THIRD FLOOR PLAN
INTERIOR IMPROVEMENTS KEY
THIRD FLOOR AREA
Lami Grubb
PRE-2
CORRIDOR
ELEVATOR LOBBY 14'-10" x 19'-8"
RESIDENT UNIT 1
RESIDENT UNIT 2
RESIDENT UNIT 3
RESIDENT UNIT 4
RESIDENT UNIT 5
RESIDENT UNIT 6
RESIDENT UNIT 7
STAIR
EQUIP. STORAGE
PUBLIC TOILET
STAFF TOILET
TELECOM EQUIP.
MED SUPPLY
PROVIDER HOSTING
OFFICE
FAMILY MEETING
FAMILY ROOM
VENDING / KITCHENETTE
RECEPTION
NURSE STATION
MEDS
SUPPLIES
COPY/ FAX
CLOS.
STAFF MEETING/ BREAKROOM
MED. WASTE
LINENS
LOCKERS
KITCHENETTE